Southwest Orthopaedic Group - Patient Registration Form

Patient Information				
Patient's Last Name, First, Middle:				DOB:
Legal Name, if different than above:		Former/Maiden Name:	SSN (Required):	Sex: ▢ Male ▢ Female ▢Other
Home Phone:	Cell Phone:	Okay to email, leave voice messages, or text you regarding appointments, test results, referrals, or for any other reason? ▢ Yes ▢ No		
Email:				
Patient's Address (Street, City, State, Zip):				
Marital Status: ▢ S ▢ M ▢ D ▢ W	Do you live in a Skilled Nursing Facility? ▢ Yes ▢ No		Is your visit due to: ▢ Work Related Injury ▢ Car Accident ▢ Other	
Preferred Pharmacy Name + Cross Streets/Town - If you don't have one, please choose one today (Required):				
Primary Care Provider (Required):			What doctor referred you here?	

Primary Insurance Information				
Is patient covered by insurance? ▢ Yes ▢ No		Primary Insurance Company:		
Policy Holder's Name:	Policy Holder's SSN:	Policy Holder's DOB:	Policy No:	Group No:
Policy Holder's Address: ▢ Same as listed above ▢ This Address:				
Patient's relationship to policy holder: ▢ Self ▢ Spouse ▢ Child ▢ Other				
Secondary Insurance Information				
Is patient covered by secondary insurance? ▢ Yes ▢ No		Secondary Insurance Company:		
Policy Holder's Name:	Policy Holder's SSN:	Policy Holder's DOB:	Policy No:	Group No:
Policy Holder's Address: ▢ Same as listed above ▢ This Address:				
Patient's relationship to policy holder: ▢ Self ▢ Spouse ▢ Child ▢ Other				

Authorization to Release Medical Information / Emergency Contact

Do you want Southwest Orthopaedic Group, and all employees thereof, to be able to discuss financial matters or medical care with any family members or other emergency contacts? This permission will be valid indefinitely and must be revoked in writing. If so, please specify who and which information below. You may discuss my financial matters or medical care with the following:

INFORMATION OK TO DISCUSS	Name	Relationship	Phone Number	Also Emergency Contact?
_____FINANCIAL _____MEDICAL CARE				YES NO
_____FINANCIAL _____MEDICAL CARE				YES NO

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Consent for Treatment, Notice of Privacy Practices Policy, and Financial Policy

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Southwest Orthopaedic Group unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needle stick (any such test shall be conducted pursuant to Southwest Orthopaedic Group's infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of Southwest Orthopaedic Gorup if any of these situations occur during your treatment period.

Consent To Treatment Of A Minor Child *(Under the age of 18)*
I authorize this office to administer services as deemed necessary to my minor child, _____. My relation to the minor child is _____.

A **Notice of Privacy Practices (NPP)** is available to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, has access to a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

As a part of our professional relationship, it is important that you have an understanding of our financial policy.

- It is your responsibility to provide us with your most current insurance and billing information.
- We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- If you have Medicaid coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and failure to notify us of Medicaid coverage will result in full financial responsibility for services rendered.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.
- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement.
- Payment in full is due upon receipt of the statement. Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be referred to a professional collection agency and/or attorney for further collection activity. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
- If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

We may charge you a fee if you fail to attend, cancel, or reschedule your appointment with less than one full business day's notice. Surgery cancellation fees are $150 if cancelled within 24hrs of your surgery.

My signature below indicates that I have read and fully understand the Consent for Treatment, Privacy Practices Policy, and Financial Policy.

Patient or Legal Representative Printed Name	Representative Relationship	Date of Birth

Patient's Signature	Date

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Assignment of Benefits and Authorization for Direct Payment

Assignment of Benefits, Assignment of Rights to Pursue ERISA and other Legal and Administrative Claims associated with my Health Insurance and/or Health Benefit Plan (Including Breach of Fiduciary Duty), Designation of Authorized Representative and Authorization for Direct Payment

I hereby assign and convey directly to Southwest Orthopaedic Group, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Southwest Orthopaedic Group, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Southwest Orthopaedic Group to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and /or attorney to release to Southwest Orthopaedic Group any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from Southwest Orthopaedic Group or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose in action arising under any group health plan, employee benefits, plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from Southwest Orthopaedic Group (including any right to pursue those legal or administrative claims or chose in action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to Southwest Orthopaedic Group all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by Southwest Orthopaedic Group, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (Southwest Orthopaedic Group) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Southwest Orthopaedic Group as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator, or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment of valid for all administrative and judicial reviews under PPACA (healthcare reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

Patient or Legal Representative Printed Name	Representative Relationship	Date of Birth

Patient's Signature	Date

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Please tell us the **REASON FOR TODAY'S VISIT** or any special concerns you would like to discuss with your doctor today.

Please list your **CURRENT MEDICATIONS**:

❑ I give SWOG permission to obtain my 2 year medication history from SureScripts.

Name of Medication	**Dosage** (ie, milligrams)	**How Taken** (ie, 1 tablet daily)

Please list any **ALLERGIES** to medications/foods:

Allergy	**Type of Reaction** (ie, rash, nausea)

Please provide your **PAST MEDICAL HISTORY** (check all that apply):

____ Anemia
____ Asthma
____ Blood Clots
____ Breast
____ Bronchitis
____ Bunions
____ Cancer
____ Carpal Tunnel
____ Colitis
____ Colon/Intestinal
____ COPD
____ Cubital Tunnel
____ Diabetes
____ Emphysema
____ Gallbladder
____ Gout
____ Heart Attack
____ Heart Disease
____ Hepatitis
____ Hiatal Hernia
____ High Cholesterol
____ Hypertension
____ Hyperglycemia
____ Hypoglycemia
____ Jaundice
____ Kidney DIsease
____ Liver Disease
____ Mental Illness
____ Migraines
____ Mitral Valve Prolapse
____ Pacemaker/Defibrillator
____ Pancreatitis
____ Pneumonia
____ Polio
____ Prostate Disease
____ Rheumatoid Arthritis
____ Rotator Cuff Injury
____ Seizures/Epilepsy
____ Sleep Apnea
____ Stent Placement
____ Stomach
____ Stroke
____ Thyroid Problems
____ Other:

Please tell us about any **SURGERIES** you have and indicate the **month/year if known:**

General Question (All Patients):	**FOR FEMALES ONLY:**
Are you being seen by a cardiologist? ▫ No ▫ Yes, Dr _____ Have you ever had any adverse reactions to anesthesia? ▫ N ▫ Y	Are you pregnant? No Unkwn Yes, due date: _____ # of Pregnancies: _____ # of Children: _____ # of Miscarriages: _____ # of Abortions: _____

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Please provide your **FAMILY HISTORY:**	Mother	Father	Sister	Brother	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Bleeding Disorders								
Cancer, Type_____								
Diabetes								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Low Blood Pressure								
Vascular Disease								
Other: _____								

Please provide your **SOCIAL HISTORY:**	
Do you **smoke**? Yes No Former Type of Tobacco: _____ Packs/Day: _____ Years Smoked: _____ Year Quit: _____	Do you drink **alcohol**? Yes No Former Type of Alcohol: _____ Frequency: _____ Amount: _____ **Other Drug Use?** Never Current Former

Review of Systems: Please circle all that apply.

Constitutional	Weight Gain, Weight Loss, Fever, Night Sweats, Exercise Intolerance
Eyes	Irritation, Dryness, Change in Vision
Ears/Nose/Throat/Mouth	Difficulty Hearing, Ear Pain, Nosebleeds, Sinus Problems, Snoring, Sore Throat, Bleeding Gums, Dry Mouth, Mouth Ulcers, Oral Abnormalities, Teeth Problems
Cardiovascular	Shortness of Breath, Palpitation, Chest Pain, Arm Pain, Heart Murmur
Respiratory	Cough, Wheezing, Shortness of Breath, Coughing Blood
Gastrointestinal	Vomiting, Diarrhea, Abdominal Pain, Loss of Appetite, Vomiting Blood
Genitourinary	Incontinence, Hematuria, Difficulty Urinating, Urination Frequency
Musculoskeletal/Extremities	Muscle Aches, Weakness, Arthralgia, Joint Pain, Back Pain, Swelling
Neurologic	Weakness, Numbness, Seizures, Headaches, Loss of Consciousness
Psychiatric	Depressed, Sleep Disturbance, Alcohol Abuse
Endocrine	Fatigue, Weight Gain, Weight Loss
Lymphatic	Buising, Swollen Glands
Allergic/Immunologic	Itching, Hives, Runny Nose, Sinus Pressure, Frequent Sneezing